RHRA Retirement Homes Regulatory Authority

FINAL INSPECTION REPORT
Under the *Retirement Homes Act, 2010*

Inspection Information	
Date of Inspection: June 8, 2023	**Name of Inspector: Angela Butler**
Inspection Type: Routine Inspection	
Licensee: ACC-002435 - Dementia Care Inc.	
Retirement Home: Highview Residences	
License Number: S0029	

About Routine Inspections

A routine inspection, performed by an RHRA inspector, is a physical inspection of a licensed retirement home. During a routine inspection, an RHRA inspector will walk through the home, speak to residents and staff, observe care services and conditions in the home, and ensure the licensee's management and staff follow mandatory policies and practices designed to protect the welfare of residents.

Following a routine inspection, the RHRA inspector prepares a draft inspection report which is sent to the licensee. The draft report may include instances where the licensee has failed to meet the standards of the *RHA*. If included, the licensee can respond to these instances and is strongly encouraged to inform RHRA of its plans to meet the standards of the *RHA*.

Following the draft report, the RHRA inspector prepares this final inspection report, incorporating any response from the licensee with their plans to meet the standards of the *RHA*. The most recent final inspection report must be posted in the home in a visible and easily accessible location. All final inspection reports from the previous two years must also be made available in an easily accessible location in the home. The licensee must provide a copy of this report to the home's Residents' Council, if one exists.

In addition to inspection reports, RHRA may provide information to a licensee to encourage improvements of their current practices.

If the licensee repeatedly does not meet the required standards, RHRA may take further action.

Focus Areas

During a routine inspection, an inspector will focus primarily on a set number of areas which have been identified as related to the health, safety and wellbeing of resident, and may take various actions to determine whether the licensee is compliant with the RHA in relating to the areas. The areas listed in this section are ones which an inspector has identified as non-compliant.

Focus Area #1: Abuse and Neglect

RHRA Inspector Findings

During the routine inspection the inspector reviewed the homes incident logs. In reviewing the incident log, there was a physical altercation between two residents that resulted in one of the residents receiving a red mark to her ear. The Licensee failed to report the incident of resident-to-resident abuse to RHRA.

Outcome

The Licensee submitted a plan to achieve compliance by Tue Aug 01, 2023. RHRA to confirm compliance by following up with the Licensee or by inspection.

Focus Area #2: Behaviour Management and Dementia Care

RHRA Inspector Findings
During the routine inspection, the inspector reviewed resident files. One resident had a consultation and received recommendations from the Geriatric Specialist to manage the resident's behaviours. The Licensee failed to include strategies for identifying and addressing triggers for responsive behaviours which are part of the home's Dementia Care program.

Outcome
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

Focus Area #3: Complaints

RHRA Inspector Findings
The inspector reviewed the Licensee's complaints log and noted that a complaint was not resolved within 10 days of receiving the complaint. Specifically, the record of the complaint did not include the final resolution to the complainant. The Licensee failed to ensure that their written record of a complaint included all the required elements.

Outcome
The Licensee has demonstrated it has taken corrective action to achieve compliance.

Focus Area #4: PASDs and Restraints

RHRA Inspector Findings
During the inspection the inspector reviewed a residents file and observed the residents living space. The inspector observed the residents bed had full bedrails attached to the bed and the resident was sitting in a tilt recline wheelchair. The staff confirmed that when the resident is in the bed both rails are elevated for safety reasons and is working well for the resident. The resident's Personal Assistance Services Device plan advises the tilt recline wheelchair is used for repositioning purposes. The PASD plan advises it has tried alternatives with no effect. In reviewing the resident's plan of care and physician's orders the inspector found there was no order from a member of a college nor was the information included in the residents plan of care as to why the resident required full bedrails or a tilt recline wheelchair. The Licensee failed to follow the requirements for restraints/PASD's as set out in the legislation.

Outcome
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

Focus Area #5: Resident Record, Assessment, Plan of Care

RHRA Inspector Findings
As part of the inspection, the inspector also reviewed records relating to the residents. The inspector confirmed that the Licensee failed to ensure that one of the residents had their plans of care were approved by a member of a College; Further, the Licensee failed to ensure that two of the residents had their plans of care updated as their care needs changed and to provide clear direction to staff who provide the care to the residents. Furthermore, the License failed to ensure that an interdisciplinary care conference was held as part of the development of the plan of care for three residents whose care needs include dementia care.

Outcome
The Licensee has advised it has taken corrective action to achieve compliance. RHRA to confirm compliance by following up with the Licensee or by inspection.

Additional Findings
During a routine inspection, an inspector may observe areas of non-compliance that are not related to the standard focus areas. In these cases, an inspector may cite the home for these contraventions at the time of this inspection. In addition, an inspector may follow-up on findings of non-compliance from previous inspections. Where the licensee is unable to demonstrate they have come into compliance or maintained compliance, an inspector may cite the home for these repeat contraventions at the time of this inspection.

Not Applicable

Current Inspection – Citations
Citations relating to the above Focus Areas or Additional Findings made during the current inspection are listed below.

The Licensee failed to comply with the RHA s. 41. (2); Dementia care program

s. 41. (2); Dementia care program
41. (2) The program shall include,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 41. (2), (e)
(e) strategies for identifying and addressing triggers for responsive behaviours if the resident exhibits responsive behaviours.

The Licensee failed to comply with the RHA s. 47. (5); Development of plan of care

s. 47. (5); Development of plan of care
47. (5) If an assessment of a resident indicates that the resident's care needs may include dementia care, skin and wound care or the use of a personal assistance services device, the licensee shall ensure that an interdisciplinary care conference is held as part of the development of the resident's plan of care and that the resident's plan of care takes into account the results of the care conference.

The Licensee failed to comply with the RHA s. 48. (1); Approval of the plan of care

s. 48. (1); Approval of the plan of care
48. (1) For the purposes of paragraph 2 of subsection 62 (9) of the Act and subject to subsection (2), the licensee shall ensure that a resident's plan of care is approved by,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 48. (1), (a)
(a) a member of the College of Physicians and Surgeons of Ontario or the College of Nurses of Ontario;

The Licensee failed to comply with the RHA s. 59. (1); Procedure for complaints to licensee

s. 59. (1); Procedure for complaints to licensee
59. (1) Every licensee of a retirement home shall ensure that every written or verbal complaint made to the licensee or a staff member concerning the care of a resident or operation of the home is dealt with as follows:

Specifically, the Licensee failed to comply with the following subsection(s):

s. 59. (1), para. 2
2. The complaint shall be resolved if possible, and a response that complies with paragraph 4 provided within 10 business days of the receipt of the complaint.

The Licensee failed to comply with the RHA s. 59. (2); Procedure for complaints to licensee

s. 59. (2); Procedure for complaints to licensee
59. (2) The licensee shall ensure that a written record is kept in the retirement home that includes,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 59. (2), (d)
(d) the final resolution, if any, of the complaint;

The Licensee failed to comply with the RHA s. 62. (12); Reassessment and revision

s. 62. (12); Reassessment and revision
62. (12) The licensee shall ensure that the resident is reassessed and the plan of care reviewed and revised at least every six months and at any other time if, in the opinion of the licensee or the resident,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 62. (12), (b)
(b) the resident's care needs change or the care services set out in the plan are no longer necessary;

The Licensee failed to comply with the RHA s. 62. (4); Contents of plan

s. 62. (4); Contents of plan
62. (4) The licensee of a retirement home shall ensure that there is a written plan of care for each resident of the home that sets out,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 62. (4), (b)
(b) the planned care services for the resident that the licensee will provide, including,

s. 62. (4), (b), 3.
(iii) clear directions to the licensee's staff who provide direct care to the resident;

The Licensee failed to comply with the RHA s. 68. (1); Restraints prohibited

s. 68. (1); Restraints prohibited
68. (1) No licensee of a retirement home and no external care providers who provide care services in the home shall restrain a resident of the home in any way, including by the use of a physical device or by the administration of a drug except as permitted by section 71.

The Licensee failed to comply with the RHA s. 69. (2); Restrictions on use

s. 69. (2); Restrictions on use
69. (2) A licensee of a retirement home or an external care provider who provides care services in the home may permit the use of a personal assistance services device for a resident of the home only if,

Specifically, the Licensee failed to comply with the following subsection(s):

s. 69. (2), (c)
(c) one or more of the following persons have approved the use of the device:

s. 69. (2), (c), 1.
(i) a legally qualified medical practitioner,

s. 69. (2), (e)
(e) the use of the device is included in the resident's plan of care;

The Licensee failed to comply with the RHA s. 75. (1); Reporting certain matters to Registrar

s. 75. (1); Reporting certain matters to Registrar
75. (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Registrar:

Specifically, the Licensee failed to comply with the following subsection(s):

s. 75. (1), para. 2
2. Abuse of a resident by anyone or neglect of a resident by the licensee or the staff of the retirement home of the resident if it results in harm or a risk of harm to the resident.

Closed Citations
During an inspection, an inspector may follow-up with areas of non-compliance cited during a previous inspection, or verify compliance with areas initially cited during the current inspection. The inspector has verified that at the time of this report, the licensee was able to demonstrate that the following areas have come into compliance.

Not Applicable

NOTICE

The Final Inspection Report is being provided to the Licensee, the Registrar of the RHRA and the home's Residents' Council, if any.

Section 55 of the *RHA* requires that the Final Inspection Report be posted in the home in a conspicuous and easily accessible location. In addition, the Licensee must ensure that copies of every Final Inspection Report from the previous two (2) years are made available in the Home, in an easily accessible location.

The Registrar's copy of the Final Inspection Report, as it appears here, will be included on the RHRA Retirement Home Database available online at http://www.rhra.ca/en/retirement-home-database.

Signature of Inspector Angela Butler RN	Date July 11, 2023